Whom may we thank for referring you to this office → _____*?*

APPLICATION FOR CARE AT *Elite Wellness Chiropractic*

[Please fill out form in ink]

Today's Date: _____ HRN: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____

Mobile Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____

Health Insurance: ❑ Yes or ❑ No Marital Status: ❑Married ❑ Single ❑Widowed Social Security #:_____

Name of Spouse: _____ Number of children and age: _____

Name & Number of Emergency Contact: _____Relationship: _____

Accident Information

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No

Please describe the accident in your own words:_____

_____

_____

Date of Accident: _____ Time of Accident: _____☐ a.m. ☐ p.m.

Road/Street Name:_____ City/State_____ Nearest Intersection:_____

Driving Conditions: ☐ Dry ☐ Wet ☐ Icy ☐ Other_____ Which direction were you headed? _____

Speed your were traveling? _____ Make & Model of vehicle you were in:_____

Were you wearing a seatbelt? ☐ Yes ☐ No If yes, what type? ☐ Lap ☐Shoulder

Was the vehicle equipped with airbags? ☐ Yes ☐ No If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No If yes, what was the position of the headrest? ☐ Low ☐ Mid-position ☐ High

Were you the: ☐ Driver ☐ Front Passenger ☐Rear Passenger ☐ Pedestrian Did your car impact another vehicle? ☐ Yes ☐ No

How many people were in the accident vehicle? _____

Did your car impact a structure? ☐ Yes ☐ No If yes, explain_____

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No If yes explain_____

Was impact from: ☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other_____ Were you: ☐ Surprised by impact ☐ Braced for impact

At the time of impact were you looking: ☐ straight ahead ☐ to the left ☐ up ☐ to the right ☐ down

Were both hands on the wheel? ☐ Yes ☐ No If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No If yes, which foot was on the brake? ☐ Right ☐ Left

Other Vehicle (If applicable)

Make and model of other vehicle_____ Which direction was other vehicle headed? ☐ North ☐ South ☐ East ☐ West

Speed other vehicle was traveling_____

Did the police come to the accident? ☐ Yes ☐ No Were there any witnesses? ☐ Yes ☐ No Was a police report filed? ☐ Yes ☐No

Was a traffic violation issued? ☐ Yes ☐ No If yes, whom?_____

HISTORY of COMPLAINT

Please identify the symptom(s) since your injury: Primarily: _____

Secondarily: _____ Thirdly: _____ Fourthly: _____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by c***ircling the number*:**

Primary or chief complaint is a: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Second complaints is a: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Third complaint is a: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Fourth complaint is a: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM ☐ All Day
How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long? _____

Describe how you felt immediately after the accident:_____

Did you go to the hospital? ☐ Yes ☐ No When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident
How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital_____ Name of doctor_____

Diagnosis_____ Treatment received_____

X-rays taken ☐ Yes ☐ No ☐ Other_____

Have you been treated or currently being treated by any other doctors a result of your injuries? ☐No ☐ Yes I**f yes,** when: _____

By whom?_____ Diagnosis_____ Treatment received_____

Are you still currently under care? ☐ Yes ☐ No If no, how long were you under care: _____

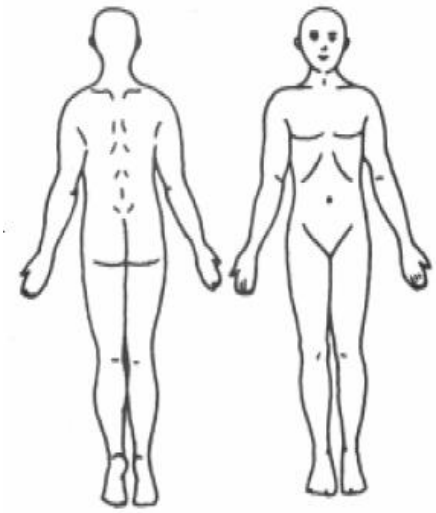
Have you been able to work since this injury? ☐ Yes ☐ No If yes, how many work days have you missed?_____

When you returned to work, have your injuries from the accident affected your work? Please explain_____

_____

_____

Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No



***PLEASE MARK** the areas on the Diagram **with the following letters** to describe your symptoms:

R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling

What relieves your symptoms? _____

What makes them feel worse? _____

Is the condition getting progressively worse? ☐ Yes ☐ No If yes, in: ☐ Frequency ☐ Intensity

Can we send a report to your primary care provider on your condition and progress? ☐ **Yes** ☐ **No**

Primary Care Providers Name: _____ **Office Name:** _____

Phone: _____ **Address:** _____

LIST MOST RESTRICTED ACTIVITIES:	**CURRENT ACTIVITY LEVEL**	**USUAL ACTIVITY LEVEL**
_____:	_____	
_____:	_____	
_____:	_____	
_____:	_____	

List any other injuries to your spine, **minor or major**, that the doctor should know about: (Birth, Sports, Falls, Work Activity)

_____

_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes:**

How many times? _____ When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: _____,

and **who** provided it: _____

How long ago? _____ What were the results. ☐ Favorable ☐ Unfavorable→ please explain_____

_____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*, C** for ***Currently*** have and **N** for *N**ever** have had***:**

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteoarthritis ___ Diabetes (Type I /II) ___Cerebral vascular ___ other serious conditions:

PLEASE, identify ALL PAST and any **CURRENT** conditions you feel may be contributing your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES→			
ADULT DISEASES →			

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. Hobbies -Recreational Activities- Exercise Regime: How does you present problem affect the following: **(See Attachment)**

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes
If yes whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister's ❑ brother's ❑ son(s) ❑ daughter(s)
Have they ever been treated for their condition? ❑ No ❑ Yes ❑I don't know
2. Any other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: _____

◆◆◆◆◆

I hereby authorize payment to be made directly to Elite Wellness Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Elite Wellness Chiropractic for any and all services I receive at this office.

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____
Doctor's Signature **Date Form Reviewed**

Patient's Name: _____ HR#: _____ ____/____/____

Activities of Daily Living/Symptoms/Medications

Patient Name: _____ File#_____

Date: _____

Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Care-Family Member	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Change Positions	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading or Concentration	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Self Care- Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Self Care- Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Exercise or Recreation	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

HEALTH CONDITIONS:

Abnormal posture and spinal distortions are the result of traumas or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called Subluxations (sub-lux-a-shuns).

It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine and create serious adverse effects on your overall health. Please mark any health conditions you are experiencing since your injury.

CERVICAL SPINE (NECK): Please mark P for in the Past, C for Currently have and N for Never

Postural distortions from subluxations in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience…?

____ Neck Pain
____ Headaches
____ Dizziness
____ Thyroid Conditions
____ Visual Disturbances
____ Hearing Disturbances
____ Poor Sleep
____ Convulsions / Epilepsy / Seizures
____ High Blood Pressure
____ Low Blood Pressure
____ Low Energy / Fatigue
____ Anxiety
____ Mood Changes
____ ADD /ADHD
____ Pain Into Your Shoulders / Arms / Hands
____ Numbness / Tingling In Arms / Hands
____ Coldness In Hands
____ Weakness In Grip
____ Sinus Problems
____ Allergies / Hay Fever
____ Recurrent Colds / Flue / Ear Infections

THORACIC SPINE (UPPER BACK): Please mark **P** for in the Past, **C** for Currently have and **N** for Never

Postural distortions from subluxations in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience…?

____ Heart Palpitations
____ Heart Attacks / Angina
____ Tachycardia
____ Heart Murmurs
____ Recurrent Lung Infections
____ Bradycardia
____ Asthma Wheezing / Shortness Of Breath
____ Recurrent Bronchitis
____ Pain On Deep Inspiration / Expiration

THOPRACIC SPINE (MID BACK): Please mark **P** for in the Past, **C** for Currently have and **N** for Never

Postural distortions from subluxations in the mid back will weaken the nerves into your ribs, chest and upper digestive tract, and affect these parts of your body. Do you experience…?

____ Mid Back Pain
____ Nausea
____ Hypoglycemia
____ Kidney Trouble
____ Pain Into Your Ribs / Chest
____ Ulcers / Gastritis
____ Tired / Irritable After Eating Or When You Haven't Eaten For Awhile
____ Gallbladder Trouble
____ Indigestion / Heartburn / Reflux
____ Diabetes

LUMBAR SPINE (LOW BACK): Please mark **P** for in the Past, **C** for Currently have and **N** for Never

Postural distortions from subluxations in the low back (resulting from Forward Head Syndrome) will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience…?

____ Recurrent Bladder Infections
____ Diarrhea
____ Constipation
___ Pain w/ Cough/Sneeze
____ Low Back Pain
____ Muscle Cramps In Your Legs / Feet
____ Sexual Dysfunction
____ Pain Into Your Hips / Legs / Feet
____ Numbness/ Tingling In Your Legs / Feet
____Difficulty Urinating
____ Menstrual Irregularities / Cramping (females)
____ Coldness In Your Legs / Feet
____ Weakness In Lower Extremity

List Prescription & Non-Prescription drugs you take: _____

_____

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain **worst possible pain**

0 1 (2) 3 4 (5) 6 7 (8) 9 10

---

1 – What is your pain RIGHT NOW?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I am advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Elite Wellness Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____  Witness Initials

Patient or Authorized person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on _____-_____-_____ (Date)

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____  Witness Initials

Patient or Authorized person's Signature Date

JDD,DC 5/2011

Elite Wellness Chiropractic NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -**we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call 512-297-2288 to speak with Dr. Lewis. If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days . If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

*Patient initials: _____**-retaining page 1 of 2***

Elite Wellness Chiropractic's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued….

I have received a copy of Elite Wellness Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at an time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____ _____
Patient's Name DOB HR#

_____ _____
Patient signature Date

_____ _____
Witness Date

JDD,DC 5/2011

OUR OFFICE POLICIES

Welcome to Elite Wellness Chiropractic

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your ***Application for Care***, please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

☐ **PATIENT PRIVACY –** Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

☐ **YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at Elite Wellness Chiropractic is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctors a myriad of techniques to accomplish this goal, including but not limited to Diversified, Pettibon, Chiropractic Biophysics, Clear Institute, and Thompson techniques. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health.

☐ **FIRST THINGS FIRST**- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

☐ **PATIENT'S REPORT OF FINDINGS** – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

Note: Patient retains the above Notice of Office Policies and Elite Wellness CHIROPRACTIC retains the signature sheet.

Patient initials: _____-retaining pages 1 of 2

I hereby acknowledge receiving a copy of the practices 'Office Policies' a two page document, the first page of which I have read and retained. This second page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies 'as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

_____ _____ __ _____

Patient's Name DOB HR#

_____ _____

Patient signature Date

_____ _____

Witness Date

JDD,DC 5/2011